DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 5

2. STATE: North Dakota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 434.20; Social Security Act 1932(a)(1)& (2)

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 7,995,089
b. FFY _____ $ 33,420,350

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 11	Page 11
Attachment 2.1-A pg i, pg 1-24	New
Supplement 1 to Attachment 2.1-A, pg 1-2	New
Supplement 2 to Attachment 2.1-A, pg 1	New
Supplement 3 to Attachment 2.1-A, pg 1	New
Supplement 4 to Attachment 2.1-A, pg 1	New

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Managed Care

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
David J. Zentner

14. TITLE:
Director, Medical Services

15. DATE SUBMITTED:
April 30, 2001

16. RETURN TO:
David J. Zentner
Director, Medical Services
ND Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
May 7, 2001

18. DATE APPROVED:
July 27, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Spencer K. Ericson

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: April 30, 2001

8. Page Number of the Plan Section or Attachment	9. Page Number of the Superseded Plan Section or Attachment
Supplement 5 to Attachment 2.1-A, pg 1	New
Supplement 6 to Attachment 2.1-A, pg 1-3	New
Supplement 7 to Attachment 2.1-A, pg 1-17	New
Supplement 8 to Attachment 2.1-A, pg 1	New
Supplement 9 to Attachment 2.1-A, pg 1	New
Supplement 10 to Attachment 2.1-A, pg 1-2	New

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: North Dakota

Citation			
42 CFR 435.914 1902 (a) (34) of the Act	2.1 (b) (1)		Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in ATTACHMENT 2.6-A.
1902 (e) (8) and 1905 (a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under Section 1902 (a) (10) (E) (i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
1902 (a) (47) and 1920 of the Act	___	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
42 CFR 434.20		(c)	The Medicaid agency elects to enter into a risk contract with an HMO that is--
		___	Qualified under title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to section 1903 (m) (3) of the Social Security Act.
		X	Not Federally qualified, but meets the requirements of 42 CFR 434.20 (c) and is defined in ATTACHMENT 2.1-A.
		___	Not applicable.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

I. General Provisions

The North Dakota Department of Human Services ("NDDHS") elects to use the State plan amendment under section 1932(a)(1) and (2) of the Social Security Act ("Act"), permitting mandatory enrollment of eligible Medicaid enrollees into managed care entities ("MCE") on the basis of NDDHS's 1915(b) waiver of the Act.

The objective of the mandatory MCE enrollment is to assure adequate access to primary care by Medicaid enrollees; improve the quality of care received by enrollees; promote coordination and continuity of health care; reduce costs; and assist enrollees to use the health care system appropriately and effectively by preventing unnecessary utilization and reducing inappropriate utilization.

The basic concept is to allow Medicaid enrollees to select a MCE to provide, through an ongoing patient/physician relationship, primary care services and referral for all necessary specialty services. The MCE is responsible for monitoring the health care and utilization of non-emergency services. Neither emergency nor family planning services are restricted.

The MCE will assist the enrollee in gaining access to the health care system and will monitor on an ongoing basis the participant's condition, health care needs, and service delivery. The MCE will be responsible for locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of enrollees enrolled in the MCE.

Enrollees will be restricted to receive services included under the managed care benefit package either from the chosen MCE or from another qualified provider to whom the participant was referred by the MCE. The enrollee's health care delivery will be managed by the MCE. The state plan's intent is to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will reinforce continuity of care and efficient and effective service delivery.

A. Managed Care Entities
   1. Managed Care Organizations ("MCO")
      a) Health Maintenance Organization ("HMO") as set forth in North Dakota Century Code ch. 26.1-18.1-01

b) Provider Sponsored Organizations ("PSO") as set forth in North Dakota Century Code ch. 26.1-01-07.6 and North Dakota Administrative Code 45-06-13.
c) Health Insuring Organization ("HIO") means an entity that in exchange for capitation payments covers services for recipients through payments to, or arrangements with, providers.
d) MCOs will be contracted on a fully capitated, comprehensive risk basis.

2. Primary Care Case Managers ("PCCM") means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services. PCCMs are contracted to provide services through North Dakota Access and Care ("NoDAC"), the NDDHS administered PCCM program. Primary care case managers are:
   a) General practitioners, family practitioners, pediatricians, internists, obstetricians/gynecologists, or other physician specialty as approved by the NDDHS in either a solo or group practice, rural health clinics ("RHC"); all federally qualified health centers ("FQHC") within the state; or all Indian Health Service facilities ("IHS") within the state.
   b) PCCMs are reimbursed on a fee-for-service basis plus a management fee. The management fee is not paid to RHC, FQHC, or IHS by reason of the inclusion of the case management fee in the encounter fee paid to these facilities.

B. MCO contracts requirements
   1. NDDHS will provide to the HCFA Regional Office MCO contracts for review and approval based on value and compliance with federal rules and regulations
   2. All contracts with MCOs will comply with pertinent sections of 1932, 1903(m) and 1905(t) of the Act.
   3. The MCO must assure the NDDHS that the MCO is an independent contractor providing services for the NDDHS and that neither the MCO nor any of the MCO's employees are employees of the NDDHS

C. Information requirements
   1. NDDHS or each contracted MCO will furnish information to enrollees and potential enrollees.
   2. By reason of the NDDHS administering the enrollment process through the county social service agencies, each county agency is able to assist enrollees and potential enrollees understand the managed care programs. In applicable counties where an MCO is available, the MCO staff will provide additional assistance to enrollees and potential enrollees to understand the requirements, benefits, and differences between plans.

3. Language
   a) Written materials, including vital documents, will be translated for eligible limited English proficiency ("LEP") language group that constitutes ten percent or 3,000, whichever is less, of enrollees to be served or likely to be directly affected by the enrollee's MCE
   b) Vital documents will be translated for eligible LEP language groups that do not fall within paragraph a) above, but constitute five percent or 1,000, whichever is less, of enrollees to be served or likely to be directly affected by the enrollee's MCE. Translation of other documents, if needed, can be provided orally
   c) A written notice of the right to receive competent oral translation of written materials in the primary language of the eligible LEP language group will be provided to enrollees that do not fall within a) and b) above, but are fewer than 100 persons in a language group to be served or likely to be directly affected by the enrollee's MCE
      1) This notice is available at the county social service agency, and will be provided upon initial medical assistance application and during continued contact with the enrollee.
   d) Statistics to measure the LEP language group will be obtained from a combination of the U.S. Census Bureau, Immigration and Naturalization Service, Lutheran Social Services, and county social service agencies.
   e) Oral interpretation services must be available from health care providers free of charge to enrollees of the MCO or PCCM program
      1) As guided by the Office of Civil Rights (OCR) of the U.S. Department of Health and Human Services' "Policy Guidance on the Title VI Prohibition against National Origin Discrimination As It Affects Persons with Limited English Proficiency"
   f) County social services agencies will notify enrollees and potential enrollees that oral interpretation and written information are available in languages other than English and how to access those services.
      1) This process is accomplished by a combination of county and state staff and private agreements with entities such as private individuals, Cultural Interpreter Services, Lutheran Social Services, and AT&T Language Line
4. Format
   All enrollment notices and informational materials must be provided in a manner and form which may be easily understood by enrollees and potential enrollees.
5. Information for potential MCO enrollees
   a) The county social service agencies or MCO will provide information to each potential enrollee residing in the MCO's service area.
      1) Information will be provided according to NDDHS's standard of promptness of 45 days. This timeframe is the maximum amount of time between the initial intake application process and eligibility authorization of the medical assistance case.

a) Required information
   1) Basic features of managed care
   2) Populations included and excluded from mandatory enrollment
   3) Populations free to choose between PCCM and MCO
   4) MCO responsibilities for coordination of care
   5) Benefits covered
   6) Cost sharing
   7) Service area
   8) Provider Directory available on-line at the NDDHS web site to allow county social service agencies to access and print for enrollees, or for enrollees to access directly. The directory will supply provider information such as name, specialty field, address, and if a physician's practice is closed.
   9) Benefits available under the State plan but not covered by MCO

2. Information for MCO enrollees
   After the MCO receives notice of the enrollee's enrollment, and once a year thereafter:
   a) Give each enrollee at least a 30 day written notice of any change in services, benefits or plan design
   b) Provide written notice of termination of a contracted provider
   c) Required information for enrollee handbook, at a minimum, should include the elements listed in Supplement 1.
3. MCO information upon request
   Upon request, the MCO shall provide enrollees or potential enrollees any of the following information upon request:
   a) MCOs and health care facilities' licensure, certification, and accreditation status.
   b) Information that includes, but is not limited to, education, licensure, and Board certification and recertification of health care professionals
   c) Information for accessing services, including factors such as physical accessibility and non-English languages spoken.
   d) A description of the procedures the MCO uses to control utilization of services and expenditures.
   e) A summary description of the methods of compensation for physicians.
   f) Information on the financial condition of the MCO, including the most recently audited information.
   g) Any information given to enrollees or potential enrollees
4. Information on PCCMs
   When potential enrollees are informed of the requirement to select a PCCM, the county social service agencies will provide information to each potential enrollee.
   a) Required information
   b) Basic features of managed care

2) Names of and non-English languages spoken by PCCMs and the locations at which they furnish services.
3) Any restrictions on the enrollee's choice of the listed PCCMs
4) How and where the enrollees may obtain benefits,
5) Cost-sharing
6) Available transportation

b) Additional information available upon request including grievance procedures available to enrollees, and how to obtain benefits during the appeals process.
c) The county social service agencies or MCO will provide information to each potential enrollee residing in the MCO's service area.
1) Information will be provided according to NDDHS's standard of promptness of 45 days. This timeframe is the maximum amount of time between the initial intake application process and eligibility authorization of the medical assistance case.

9. Comparative Information
NDDHS will make available a list identifying the MCEs available in the service area and information relating to:
a) benefits covered and cost sharing
b) service area
c) to the extent available, quality and performance indicators in a comparative or chart like format.

D. Provider discrimination prohibited
1. An MCO may not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.
2. If an MCO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.
3. This does not restrict the MCO:
a) To contract with providers beyond the number necessary to meet the needs of its enrollees
b) From using different reimbursement amounts for different specialties or for different practitioners in the same specialty
c) From establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

II. State Responsibilities

A. The NDDHS will adhere to State of North Dakota laws, codes, rules and regulations for the process of public notification to ensure public involvement in the Medicaid managed care program.

B. Enrollment
1. Eligible populations
With the exceptions of the excluded populations defined in B.2.b or as otherwise noted, the population identified below is mandatorily required to select a MCE
   a) Categorically needy
      1) Family Coverage Group (1931)
      2) Transitional (extended) Medicaid
   b) Optionally Categorically Needy
   c) Medically Needy (nonexempt)
      1) eligible for PCCM only
   d) Poverty Level
      1) Pregnant women
      2) Children to age 6
      3) Children ages 6 to 19
2. Excluded populations
The population identified below will be excluded from mandatory enrollment
   a) Enrollees under age 19 with special needs that are:
      1) Eligible for SSI
      2) Eligible under section 1902(e)(3) of the Act
      3) Eligible under a Maternal Child Health Services Block Grant
   b) All Dual Eligible Medicare enrollees
   c) Individuals residing in a nursing facility
   d) Individuals residing in an ICF/MR
   e) Enrollees receiving home and community based services
   f) Disabled enrollees
   g) Blind enrollees
   h) Aged enrollees
   i) Residents of the State Hospital
   j) Enrollees receiving foster care, IV-E and non-IV-E
   k) Enrollees receiving adoption assistance, IV-E and non-IV-E
   l) Enrollees receiving refugee assistance
   m) Enrollees having a retroactive eligibility period

3. In accordance with 1932(a)(1) and (2) of the Act, permitting mandatory enrollment of Medicaid enrollees into MCE, the NDDHS assures IHS facilities within the state will be PCCM. Thus allowing Native American Indians to be mandatory enrolled, and consequently the use of this state plan amendment.
4. Enrollment process
   The State administers the enrollment process through the county social service agency. At the time of application, the enrollee is informed of the need to select a MCE for each eligible member of the Medicaid unit. A continuous open enrollment period is conducted during which the MCE accepts all eligible enrollees in the order in which they apply without regard to health status of the enrollee or any other factor(s).
   a) The following process is in effect for enrollment in an MCE:
      County eligibility workers provide the enrollee with:
      1) a booklet explaining the program, its covered and non-covered services, out-of pocket costs, toll free and local telephone numbers to call for questions, and complaint procedures
      2) in counties where there is a choice between MCO(s) and PCCM, a comparative brochure is distributed
      3) a verbal explanation of the program
      4) a list of MCEs serving the enrollee's geographical area including the identity, locations and availability of health care providers that participate with the MCE
      5) county eligibility workers cannot influence the enrollee's decision on which MCE to select, only offer information
      6) the enrollee may notify the state by mail, telephone, or in person of their choice of MCE
      7) The MCE will be informed of the enrollee's enrollment:
         (a) if PCCM - by the remittance advice issued with the case management fee
         (b) if MCO - For each month of coverage throughout the term of the contract, the NDDHS shall transmit the MCO enrollment notification file to the MCO. Enrollment information will provide the MCO with identifying information about its Medicaid enrollees.
      8) Effective date of enrollment
         (a) PCCM - the date the enrollees selects the providers as the PCCM
         (b) MCO - the first day of the month following the month in which the person elects MCO enrollment. The enrollee will be exempt from any managed care requirements (open access to all services) for the time period between the date of MCO selection and effective date of enrollment.
      9) The enrollee will be issued an enrollment card

10) Enrollees will be advised which providers offer any special services such as different languages, interpretation services for the deaf, etc. offered by MCEs.

b) NDDHS has no automatic default enrollment process, but uses the process described in Supplement 8.

C. Individuals will have a choice of at least two MCE. In counties with only the NoDAC program, individuals will have a choice of at least two PCCMs. In counties where only one MCO is available, the state will offer NoDAC as the alternative MCE.

D. MCE requested disenrollment
1. The MCE may request disenrollment or exemption from enrollment for specific cases or persons where there is good cause. Good cause includes, but is not limited to the reasons in Supplement 3.
2. The MCE may not request disenrollment because of a change in the enrollee's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except where his or her continued enrollment in the MCE seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees)

E. Voluntary Disenrollment/Transfer
1. All enrollees shall have the right to request disenrollment/transfer from MCO or PCCM provider
2. The enrollee (or his or her representative) must submit an oral or written request to the county social service agency
3. The county eligibility worker and MCO must inform each enrollee of their right to request disenrollment/transfer at the time of enrollment.
4. Enrollees may request a change in their MCE:
   a) any time during the first ninety days;
   b) every six months; or
   c) if they have good cause.
   When a good cause request is made to change the MCE, the eligibility worker needs to determine if good cause exists and document the reason and decision. The worker determines the appropriate good cause change reason to use. Notification of denial of good cause must be provided to the enrollee. (See Supplement 4 for good cause reasons)
5. Voluntary disenrollment from a PCCM is effective the day the request is received.

6. Voluntary disenrollment from an MCO is effective the first day of the second month after the month in which the enrollee's request is received and processed (42 CFR 434.27).
7. Enrollees who request a change of their PCP six times within a twelve month period will be referred to the Surveillance Utilization Review System (SURS) staff to determine if over utilization patterns exist and could be subjected to the Lock-In Program
   a) The Lock-In Program is a process used to limit an enrollee's medical care and treatment to a single physician or other provider in order to prevent continued misutilization of services. Lock-in may be imposed by NDDHS on an enrollee who has misutilized services including, but not limited to, excessive services from more than one provider when there is little or no evidence of a medical need; drug acquisition in excess of medical need; and excessive utilization of emergency services. Lock-in may be imposed only on an individual enrollee and may not be imposed on an entire medical assistance unit. An enrollee may appeal the decision to impose lock-in.

F. Continued services to enrollees
   1. Medicaid enrollees whose MCE contract is terminated or who disenroll from an MCE for any reason other than ineligibility for Medicaid can access non-exempt Medicaid services once another MCE is selected.
   2. Exempt services such as emergency or family planning can be accessed at any time
   3. Inpatient hospital services provided during an entire inpatient hospital stay for an individual who enrolls in or disenrolls from the MCO's program while hospitalized will be paid by:
      a) The NDDHS if a Medicaid enrollee is admitted to an inpatient hospital prior to an effective enrollment date in the MCO's program and remains in the inpatient hospital setting on or after that effective enrollment date; and
      b) The MCO if a Medicaid enrollee in the MCO's program is admitted to an inpatient hospital prior to an effective disenrollment date and the enrollee remains in the inpatient hospital setting on or after the effective disenrollment date.

G. Monitoring procedures
   1. The MCO must submit quarterly and annual reports to monitor enrollment and disenrollment, grievances and appeals, and all other provisions of the contract, as appropriate.

III. Enrollee Rights and Protections

A. Enrollee rights.
   1. An enrollee of an MCE has the following rights:
      a) To receive information in accordance with Section I.C. Information Requirements
      b) To be treated with respect and with due consideration for his or her dignity and privacy
      c) To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand
      d) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
   2. An enrollee of an MCO also has the following rights:
      a) To be furnished health care services in accordance access standards
      b) To obtain a second opinion from an appropriately qualified health care professional
      c) To request and receive a copy of his or her medical records, and to request that they be amended or corrected
   3. Enrollees are free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCE and its providers or the NDDHS treat the enrollee.

B. Provider-enrollee communications
   1. The MCE may not restrict or interfere with a health care provider's ability to advise enrollees about medically necessary treatment options. The MCE shall comply with any state or federal statute, rule, or regulation intended to limit or prevent restriction on, or interference with, communications between a health care provider and an enrollee concerning medically necessary treatment options.
   2. An MCE that violates the prohibition of provider-enrollee communication is subject to sanction.

C. Marketing activities
   1. Contract requirements
      a) The MCE must submit to the NDDHS for prior written approval a marketing plan, which will remain confidential, and all marketing materials and agrees to engage only in marketing activities which are preapproved

b) The NDDHS will review these materials and approve or disapprove them within 30 days.
c) The MCE must market to the entire service area under the contract
d) The MCE may not assert or imply that an enrollee will lose Medicaid benefits if he or she does not enroll in the MCE's plan
e) The MCE may not discriminate against any eligible individual on the basis of health status, past medical utilization, or need for future health care services
f) The MCE may not market or advertise a benefit of service unless it is clearly specified in the contract or unless it is a special program offered
g) Marketing materials cannot contain false and materially misleading information.
h) The MCE cannot offer other insurance products as inducement to enroll.
i) The MCE must not commit marketing fraud
j) The MCE must comply with federal requirements for provision of information including accurate oral and written information

2. In reviewing the marketing materials submitted by the MCE, the NDDHS will consult with and obtain approval from the Medical Care Advisory Committee

D. Liability for payment
MCOs must provide that its enrollees are not held liable for:
1. MCO debts, in the event of insolvency
2. Covered services provided to the enrollee, for which NDDHS does not pay the MCO
3. Covered services provided to the enrollee, for which NDDHS, or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement
4. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO provided the services directly.
   a) Enrollees may only be held liable for the nominal established cost sharing amounts and not the balance of a claim that has been paid by the MCE.

E. Cost sharing
If the MCE imposes cost sharing on Medicaid enrollees, it must be in accordance with 42 CFR 447.50 through 447.60.

F. Emergency and post-stabilization services.

1. Emergency medical condition is defined as, but limited to, a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence or immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant women the health of the woman or her unborn child, in serious jeopardy.
2. Emergency services are covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or stabilize an emergency medical condition
3. Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition.
4. To enrollees and potential enrollees upon request, and to enrollees during enrollment and at least annually thereafter, the NDDHS and each MCO, must provide, in clear, accurate, and standardized form, information that describes or explains:
   a) The definitions of emergency medical condition, emergency services, and post-stabilization services
   b) Prior authorization is not required for emergency services
   c) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent.
   d) The locations of any emergency settings and other locations at which MCE providers and hospitals furnish emergency services and post-stabilization services covered under a contract
   e) The enrollee has a right to use any hospital or other setting for emergency care
   f) The post-stabilization care services
5. Coverage and payment
   a) MCO or the NDDHS through its PCCM program are responsible for coverage and payment of emergency services and post- stabilization care services.
   b) MCO or the NDDHS through its PCCM program must cover and pay for emergency services regardless of whether the provider furnishing the services has a contract with the MCO or PCCM

c) MCO or the NDDHS through its PCCM program may not deny payment for treatment obtained if an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition, or a representative of the MCO or PCCM instructs the enrollee to seek emergency services

d) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

e) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCEs as responsible for coverage and payment.

G. Solvency standards

1. An MCO must meet the solvency standards set forth in the following and as listed in Supplement 7:
   a) in North Dakota Century Code ch. 26.1-18.1 for HMOs
   b) North Dakota Administrative Code 45-06-13 for PSOs
   c) the appropriate rules and regulations that apply to an HIO's line of business as established and administered by the North Dakota Department of Insurance.
2. An MCO is exempt from these requirements if the MCO meets any of the following conditions:
   a) Does not provide both inpatient hospital services and physician services
   b) Is a public entity
   c) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers
   d) Has its solvency guaranteed by the State

IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

A. State quality strategies
1. To assure quality of health care services in the managed care programs, MCEs are required to establish a program to promote quality and accessibility of care to enrollees
2. Conduct periodic reviews to ensure compliance and evaluate the effectiveness of the strategy and update as appropriate
3. Establish contractual requirements to meet certain NDDHS-specified standards
4. Monitor and evaluate for compliance with standards
5. Assure performance measures and levels consistent with section 1932(c)(1) of the Act.
6. Arranging for external independent quality reviews (see Supplement 9 concerning external quality review and EQRO).

B. Availability of services and capacity
1. Assurance that all covered services are available, accessible and that the MCO has the network capacity to serve the expected enrollees in its service area.
2. Direct access to a women's health specialist to provide routine and preventive health care services
3. Second opinion must be available at no cost to the enrollee
4. If an MCO seeks an expansion of its service area, the MCO must demonstrate sufficient numbers and types of providers to meet the additional volume and types of services the added enrollees may require.
5. MCO must coordinate with out-of-network providers concerning payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.
6. Each MCE must meet standards for timely access to care and services
   a) Standard for the time period between scheduling a medical appointment and the appointment date, for non-emergent or non-urgent care, is 75% within 1 week, 90% within 2 weeks.
   b) See Supplement 10 concerning statistics
7. Provider services must be available 24 hours a day, 7 days a week, when medically necessary

C. Coordination and continuity of care
1. The NDDHS, through its monthly electronic transmission of enrollment to MCOs, provides ages and identifies pregnant women.
2. Each MCO must make a best effort attempt to perform an initial screening and assessment for all enrollees within 90 days from the date of enrollment. For any enrollee the screening identifies as being pregnant or having special health care needs, a comprehensive health assessment should be performed no later than 30 days from the date of identification.

3. For pregnant women and for enrollees determined to have special health care needs, each MCO must implement an appropriate treatment plan
4. Each MCO must implement a coordination program that meets NDDHS requirements and:
   a) Ensures that each enrollee has an ongoing source of primary care
   b) Ensure referrals for medically necessary care
   c) Ensure provision of care in emergency situations, including an education process
   d) Has in effect procedures to address factors (such as a lack of transportation) that may hinder enrollee compliance with medical treatments
   e) Ensures that its providers have the information necessary for effective and continuous patient care and quality improvement, consistent with the confidentiality and accuracy requirements

D. Coverage and authorization of services.
1. Each MCO must make available the services it is required to offer at least in the amount, duration, and scope that are specified by the NDDHS and are sufficient to reasonably be expected to achieve the purpose for which the services are furnished.
2. Each MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition
3. Each MCO may place appropriate limits on a service on the basis of criteria such as medical necessity (as defined by NDDHS); or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose
4. Each MCO must notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
   a) Timeframe for standard authorization decisions may not exceed 10 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days
   b) Timeframe for expedited authorization decisions may not exceed 72 hours after receipt of the request, with a possible extension of up to 14 additional calendar days.
5. Utilization management activities should not be structured so as to provide incentives to deny, limit, or discontinue medically necessary services to any enrollee

E. Credentialing and recredentialing
The MCO shall establish and verify minimum credentialing and recredentialing criteria for all professional participating providers

F. Confidentiality and accuracy of enrollee records
Each MCO must establish and implement procedures to:
1. Maintain the records and information in a timely and accurate manner
2. Protect the confidentiality of any material and information concerning an enrollee, in accordance with relevant laws, regulations, and policies, including NDDHS Manual Chapter 110-01, Confidentiality, and 42 CFR 431 subpart F.
3. Ensure that each enrollee may request and receive a copy of records and information pertaining to him or her and request that they be amended or corrected in accordance with the Health Insurance Portability and Accountability Act of 1996.
4. Ensure that each enrollee may request and receive information on how the MCO uses and discloses information that identifies the enrollee.

G. Subcontracting
1. The MCO shall have no right to and shall not assign, transfer, delegate, or subcontract the contract or any right or duty arising under the contract without the written approval of the NDDHS
2. Any subcontracting arrangements must comply with 42 CFR 434.6(b) and (c).

H. Performance Improvement
1. Each MCO must conduct performance improvement projects that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.
   a) Performance improvement projects are MCO initiatives that focus on clinical and non- clinical areas, and that involve the following:
      1) Measurement of performance using objective quality indicators.
      2) Implementation of system interventions to achieve improvement in quality.
      3) Evaluation of the effectiveness of the interventions.
      4) Planning and initiation of activities for increasing or sustaining improvement.
   b) Each project must represent the entire Medicaid enrollee population
   c) Each MCO initiate each year one or more projects among the required clinical and non-clinical areas
   d) Clinical areas include:
      1) Prevention and care of acute and chronic conditions;
      2) High-volume services;
      3) High-risk services; and
      4) Continuity and coordination of care.

e) Non-clinical areas include:
   1) Grievances and appeals;
   2) Access to, and availability of, services; and
   3) Cultural competence.

f) In addition to requiring each MCO to initiate its own performance improvement projects, the NDDHS may require that an MCO to conduct particular performance improvement projects on a topic specified by the NDDHS and participate annually in at least one Statewide performance improvement project.

2. The NDDHS must review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program.

I. Health information systems
The NDDHS must receive assurance that each MCO maintains a health information system that collects, analyzes, integrates, and reports data and makes all collected data available to the NDDHS and upon request to HCFA

V. GRIEVANCES AND APPEALS

A. Enrollee may present grievances to the MCO or the NDDHS, regarding any aspect of service delivery provided or paid for by the MCO.

B. Each MCO must have a system that includes a grievance process, an appeal process, and access to the NDDHS's fair hearing system.

C. The MCO shall acknowledge receipt of a grievance if orally (to be followed in writing) or in writing and must notify the enrollee that he or she has 30 days from the date of an adverse decision or 15 days from the issuance of a final decision on a grievance, whichever is later, to appeal to the NDDHS by requesting a fair hearing.

If the MCO or any of its participating providers authorizes a course of treatment, but subsequently decides to terminate, suspend, or reduce the course of treatment, and the decision is not mutually agreeable to the enrollee, the MCO or its participating provider must take the following actions:

1. Mail a written notice to the enrollee 10 days prior to termination, suspension, or reduction of the course of treatment, unless the determination is made less than 10 days before the conclusion of the course of treatment, in which case notice must be sent as soon as possible. Such notice shall inform the enrollee of the action being taken, the reason for the action, the specific regulations that support the action, and the enrollee's right to grieve the action; and
2. Should the enrollee file a grievance prior to the date the services are suspended, terminated, or reduced, the course of treatment shall be maintained until the grievance is resolved, an appeal to the NDDHS is resolved, or the course of treatment is concluded, whichever is earlier.
3. Nothing in this section prevents the MCO or the NDDHS from requiring prior authorization or that care be medically necessary; or from setting uniform limits on services as long as those limits are not more restrictive than Medicaid's limits. This section does not apply to courses of treatment initiated prior to an enrollee becoming an enrollee of the MCO.

D. The MCO shall inform applicants and enrollees of services provided through this contract of any right there may be to present grievances to the MCO and the NDDHS, upon enrollment, and annually thereafter.

E. The NDDHS must approve the MCO's grievance procedure in writing.

F. The MCO grievance procedure should include, but is not limited to the elements listed in Supplement 5.

G. In situations requiring urgent care or emergency care the NDDHS will require the MCO to expedite resolution of disputes, appeals, and grievances.
   1. Expedited decision for services that meet the definition of emergency medical conditions must be communicated to the enrollee as expeditiously as possible, but no later than 24 hours following receipt of an expedited review.
   2. Expedited decision for immediately and urgently needed services that do not meet the definition of emergency medical condition must be communicated to the enrollee as expeditiously as possible, but no later than 24 hours following receipt of an expedited review.
   3. Expedited decision for services that require prior authorization or for a requested inpatient stay or service(s) must be communicated to the enrollee as expeditiously as possible, but no later than 72 hours following receipt of an expedited review.

H. The MCO shall submit to the NDDHS a quarterly report summarizing each grievance handled during the quarter.

I. A final grievance decision by the MCO may be appealed by the enrollee to the NDDHS. The NDDHS shall notify the MCO of an enrollee's request for NDDHS review. The MCO shall participate in NDDHS reviews. The NDDHS shall review such appeals and reserves the right to affirm, modify, or reject the final grievance decision of the MCO at any time after an appeal is filed by the enrollee. The MCO shall abide by the decision of the NDDHS. Any decision made by the NDDHS pursuant to such a review shall be subject to review under North Dakota Century Code ch. 28-32.

VI. Certifications and Program Integrity Provisions

As a condition for contracting and for receiving payment under the Medicaid managed care program, an MCO and its subcontractors must comply with the following certification and program integrity requirements:

A. If payments to the MCO are based on data submitted by the MCO, the MCO must certify to the accuracy, completeness and truthfulness of data.

B. Regardless of whether payment is based on data, each MCO must concurrently certify that it is in substantial compliance with its contract.

C. The MCO must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

VII. Sanctions

A. In addition to exercising termination of provisions, the NDDHS may impose sanctions on the MCO including but not limited to civil money penalties, appointment of temporary management, granting enrollees the right to terminate enrollment without cause, suspension of all new enrollment, or suspension of payment for enrollees enrolled after the effective date of the sanction.

B. The NDDHS determination to impose a sanction may be based on findings from onsite survey, enrollee or other complaints, financial status, any other source, or acts or fails to act as follows:
   1. Fails to provide medically necessary services that the MCO is required to provide, under law or under its contract with the NDDHS
   2. Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
   3. Acts to discriminate among enrollees on the basis of their health status or need for health care services.
   4. Misrepresents or falsifies information that it furnishes to HCFA or to the NDDHS
   5. Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
   6. Fails to comply with the requirements for physician incentive plans
   7. An MCO or a PCCM distributes directly or indirectly, marketing materials that have not been approved by the NDDHS or that contain false or misleading information.
   8. An MCO violates any of the requirements in section 1903(m) of the Act and implementing regulations, or an MCO or a PCCM violates any of the requirements of section 1932 of the Act and implementing regulations.

C. The NDDHS has the authority to terminate an MCO or PCCM contract and enroll that entity's enrollees in other MCOs or PCCMs, or provide their Medicaid benefits through other options included in the State plan, if the State determines that the MCO or PCCM has failed to carry out the substantive terms of its contract or has failed to meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Act.

D. Notice of sanction and pre-termination hearing.
   1. Before imposing any of the alternative sanctions, the NDDHS must give the MCO timely written notice that explains the basis and nature of the sanction, and any other due process protections that the State elects to provide.

2. Before terminating the MCO or PCCM contract, the NDDHS must provide the MCO or PCCM a predetermination hearing. The NDDHS must:
   a) Give the MCO or PCCM written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;
   b) After the hearing, give the MCO or PCCM written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination;
   c) For an affirming decision, give enrollees of the MCO or PCCM notice of the termination and information, and their options for receiving Medicaid services following the effective date of termination.

VIII. Conditions for Federal Financial Participation

A. FFP is available under an MCO contract for the periods during which the MCO and the NDDHS are:
   1. in compliance with the contract in effect; and
   2. the MCO and its subcontractors are in compliance with the physician incentive plan requirements of 42 CFR 417.479 .and 42 CFR 434.70(a)(3)

B. FFP is available under a comprehensive risk contract upon prior approval by the HCFA Regional Office

C. Excluded from receiving FFP
   1. An entity being controlled by a sanctioned individual
   2. An entity that has a contractual relationship with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act
   3. An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with any individual or entity excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act or any entity that would provide those services through an excluded individual or entity.

D. Limit on payments in excess of capitation rates
   FFP is not available for payments pursuant to risk corridors or incentive arrangements that exceed 105 percent of that portion of the aggregate amount approved capitation payments attributable to the enrollees or services covered by the risk corridor or incentive management.

IX. Payment for Services

The MCE must require providers to submit all claims no later than 12 months from the date of service. The MCE must pay 90 percent of all clean claims from practitioners within 30 days of the date of receipt. The MCE must pay 99 percent of all clean claims from practitioners within 90 days of the date of receipt. The MCO must pay all other claims, except claims for excluded or unauthorized services, within 12 months of the date of receipt.

Required information for enrollee handbook

1. The 24-hour per-day phone number which can be used for assistance in obtaining emergency care or for prior authorization

2. Information on covered services including amount, duration, and scope available through the MCO

3. A Provider directory listing local participating providers, location of facilities, and information on how to choose a participating provider

4. Hours of service availability including after-hours and emergency coverage

5. Informal and formal grievance appeal procedures including timeframes, the processes for filing a grievance, appeal rights to the NDDHS to challenge the failure of the MCO to cover a service, and the right to access the NDDHS fair hearing process

6. Voluntary and special disenrollment policies

7. Health Tracks policies

8. Family planning policies

9. Policies and rules on the use of emergency and urgent care facilities, and post-stabilization services

10. Limited MCO liability for services from non-participating providers and benefits available under the State plan but not covered by MCO

11. Procedures for obtaining benefits, including authorization requirements and the appropriate use of health care services in a managed care system

12. A written description of treatment policies and any restrictions or limitations on services

13. Rights and responsibilities of members

14. Contractor's policy on referrals for specialty care

15. Procedures for changing practitioners

16. Enrollee rights

17. Restrictions on the enrollee's freedom of choice among network providers

18. Cost sharing

19. Information on how to obtain continued services

20. Additional information that is available upon request, and how to request that information.

Criteria are used to assist enrollees who do not choose an MCO or PCCM

Selection Criteria

A. Residence - The recipient will select a provider in the recipient's community or county of residence, or surrounding area. Consideration should be given to:
   1. the selection of a provider that meets the medical needs of the recipient; and
   2. The travel expense of selecting a physician not located in the recipient's community. If a recipient selects a PCP outside of their community, and similar medical services are available within the community, travel expenses are not covered services and are the responsibility of the recipient.

B. Historical Usage - Recipients will select first the PCP from which they most recently received services within the past twelve months if the PCP continues to reside in the recipient's community or county of residence or surrounding area, and the PCP will accept the recipient.

Selection Procedures

A. Primary Care Physicians are considered physicians practicing in the following medical fields: Family Practitioners, Internists, Pediatrician, and Obstetrics/Gynecology. Facilities that may be selected as a PCP include Federally Qualified Health Center, Rural Health Clinics and Indian Health Clinics.

B. All family members must select one of the PCPs described above. Children may select pediatricians, depending upon the pediatrician's patient age criteria. All children in a family may select the same or different providers depending upon the above criteria.

Pregnant members can obtain the services of an obstetrician without selecting the obstetrician as their PCP. They must select a PCP, as previously identified, for other services not related to pregnancy.

Good cause reasons for the MCE to request disenrollment or exemption of enrollees from enrollment

1. Has committed acts of physical or verbal abuse that pose a threat to providers or other enrollees of the MCE

2. Has allowed a non-enrollee to use the MCE-issued certification card to obtain services

3. Has moved outside the enrollment area

4. Has violated rules of the MCO stated in the evidence of coverage or enrollee handbook

5. Has repeatedly violated rules adopted by the Commissioner of Insurance for enrollment in an HMO

6. Is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of a recipient for this reason is only permitted if the MCE can demonstrate that it provided the recipient with the opportunity to select an alternative MCE, made a reasonable effort to assist the enrollee in establishing a satisfactory provider-patient relationship, and informed the recipient that the recipient may file a grievance on this matter.

Good cause reason for enrollee request to change the MCE

1. Recipient Relocated (RR)

2. Significant changes in the recipient's health require the selection of a PCP with a different specialty (Health status (HS))

3. PCP relocates (PR)

4. PCP refuses to act as a PCP or refuses to continue to act as a PCP (RE)

5. Redetermination of Medicaid Eligibility (RD)

6. No longer an enrolled Medicaid provider (NP)

7. Agency discretion (AG)

8. Pended PCP selection (PE) - A PCP selection can be pended if the previous PCP is no longer an enrolled provider and the recipient has not made a new selection.

9. Exempt from requirement (EX) - A recipient is temporarily exempt from selecting a PCP only if they are not able to find a physician who will agree to be designated as their PCP. All claims will be paid during an exempt period.

10. Change from HMO to PCP due to RL (RL)

11. Change to or from HMO (HM)

12. Disabled Newborn (DS)

MCO grievance procedure

A. Written policies and procedures which detail what the grievance system is and how it operates.

B. Contact person in the MCO's office to receive complaints and be responsible for routing and processing.

C. An informal grievance process which enrollees can use to make verbal complaints, to ask questions, and get problems resolved without going through the formal, written grievance process.

D. Formal grievance process which enrollees can use to complain in writing.

E. A mechanism to inform enrollees about the existence of the formal and informal grievance processes.

F. A mechanism to respond to written complaints in writing within 10 days of receipt of complaint. In cases of emergencies, than expedited response must be made by the next business day.

G. A mechanism by which enrollees can appeal any negative response to their complaint to the board of directors of the MCO. The MCO board of directors may delegate this authority to review appeals to a grievance appeal committee, but the delegation must be in writing. In either case, enrollees must be informed of the MCO's final decision, in writing, within 30 days of receipt of complaint.

H. A record keeping system for informal (verbal) grievances in the form of a written "log" which includes a short, dated summary of the problem, the response, and the resolution.

I. A record keeping system for formal (written) grievances which includes a copy of the original grievance, the response, the resolution, and the date of the quarterly report that was sent to the NDDHS and that included a summary of the grievance.

J. A mechanism to provide written notice to the enrollee who complains, at the time of the final grievance decision, that, if the final grievance decision is adverse to the enrollee:
   1. The enrollee has the right to appeal the decision to the NDDHS, in writing, within 15 days of the mailing of the adverse final grievance decision;
   2. The enrollee has the right to request that the hearing before the NDDHS be de novo; and
   3. The adverse final grievance decision will be implemented pending the agency appeal.

NORTH DAKOTA MEDICAID MANAGED CARE SERVICES

Services	PCCM Services	Referal for PCCM Serivces	MCO Services
Acupuncture	No		No
Ambulance Services	Yes		Yes
Ambulatory Surgical Services	Yes	Yes	Yes
Chemical Dependency Services	Yes		Yes
Chiropractor	Yes		Yes
Cosmetic Surgery	No		No
Dental Services, Routine	Yes		No*
Durable Medical Equipment	Yes	Yes	Yes
Emergency Services	Yes		Yes
Emergency Services/follow-up	Yes	Yes	Yes
Experimental Services and Procedures	No		No
Family Planning Services	Yes		Yes
Health Tracks Screenings	Yes		Yes
Hearing Services	Yes	Yes	Yes
Home Health Care	Yes	Yes	Yes
Hospice	Yes	Yes	Yes
Hospital Services, Inpatient	Yes	Yes	Yes
Hospital Services, Outpatient	Yes	Yes	Yes
Immunizations	Yes		Yes
In-vitro Fertilization and Embryo Transplantation or Implantation	No		No

Services	PCCM Services	Referal for PCCM Serivces	MCO Services
Lab, X-ray, and Radiology Services	Yes		Yes
Massage Therapy	No		No
Mental Health Services	Yes		Yes
Mid-level Practitioner Services	Yes		Yes
Nutritional Services	Yes	Yes	Yes
Obstetric and Gynecologic Services	Yes		Yes
Occupational Therapy	Yes	Yes	Yes
Ophthalmologic Services	Yes		Yes
Optometric Services	Yes		No*
Oral Surgery	Yes	Yes	Yes
Orthodontic services provided through Health Tracks Program	Yes		No*
Physical Therapy	Yes	Yes	Yes
Physician Services	Yes	Yes	Yes
Podiatric Services	Yes		Yes
Prescription Drugs	Yes		No*
Private Duty Nursing Services	Yes	Yes	Yes
Prosthetic Devices	Yes		Yes
Public Health Unit Services	Yes		Yes
Reconstructive Surgery	Yes	Yes	Yes
Reversal of Sterilization	No		No
Speech Therapy Services	Yes	Yes	Yes

Services	PCCM Services	Referal for PCCM Serivces	MCO Services
Transplant Services	Yes	Yes	Yes
Transportation - Non-emergency)	Yes		Yes
Workers Compensation Services	No		No

* Carve-out Service - These MCO services are not covered by the MCO but remain covered and accessible through the Medicaid program on a fee-for-service basis.

North Dakota Century Code and North Dakota Administrative Code

26.1-18.1-12. Protection against insolvency.

1. Net worth requirements.

   a. Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial net worth of one million dollars and shall thereafter maintain the minimum net worth required under subdivision b.

   b. Except as provided in subdivisions c and d, every health maintenance organization must maintain a minimum net worth equal to the greater of:

      (1) One million dollars;

      (2) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first one hundred fifty million dollars of premium and one percent of annual premium on the premium in excess of one hundred fifty million dollars;

      (3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner; or

      (4) An amount equal to the sum of:

         (a) Eight percent of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

         (b) Four percent of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

   c. A health maintenance organization licensed before August 1, 1993, and licensed only in this state must maintain the minimum requirements which are in effect at the time this chapter became law.

   d. (1) In determining net worth, no debt may be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated.

      (2) The interest expenses relating to the repayment of any fully subordinated debt must be considered covered expenses.

(3) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, may not be considered a liability and must be recorded as equity.

2. Deposit requirements.
   a. Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a value of not less than three hundred thousand dollars.

   b. A health maintenance organization that is licensed only in this state and is in operation on August 1, 1993, shall make a deposit equal to one hundred thousand dollars.

   c. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

   d. All income from deposits is an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities must be approved by the commissioner before being deposited or substituted.

   e. The deposit must be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit is an asset subject to the provisions of the liquidation act.

   f. The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, insurance commissioner, or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of the health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to the effect, duly authenticated by the appropriate state official holding the deposit.

3. Liabilities. Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of the claims. The liabilities must be computed in accordance with rules adopted by the commissioner upon reasonable

consideration of the ascertained experience and character of the health maintenance organization.

4. Hold harmless.

   a. Every contract between a health maintenance organization and a participating provider of health care services must be in writing and must set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee is not liable to the provider for any sums owed by the health maintenance organization.

   b. In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider may not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

   c. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

5. Continuation of benefits. The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering a plan, the commissioner may require:

   a. Insurance to cover the expenses to be paid for continued benefits after an insolvency.

   b. Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollee's discharge from inpatient facilities.

   c. Insolvency reserves.

   d. Acceptable letters of credit.

   e. Any other arrangements to assure that benefits are continued as specified above.

6. Notice of termination. An agreement to provide health care services between a provider and a health maintenance organization must require that if the provider terminates the agreement, the provider shall give the organization at least sixty days' advance notice of termination.

26.1-18.1-13. Uncovered expenditures insolvency deposit.

1. If at any time uncovered expenditures exceed ten percent of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit must at all times have a fair market value in an amount of one hundred twenty percent of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and must be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

2. The deposit required under this section is in addition to the deposit required under section 26.1-18.1-12 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from the deposits or trust accounts is an asset of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

3. A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if a substitute deposit of cash or securities of equal amount and value is made, the fair market value exceeds the amount of the required deposit, or the required deposit under subsection 1 is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the commissioner.

4. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures must be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining must be paid into the liquidation or receivership of the health maintenance organization.

5. The commissioner may by regulation prescribe the time, manner, and form for filing claims under subsection 4.

6. The commissioner may by rule or order require health maintenance organizations to file annual, quarterly, or more frequent reports as the commissioner deems necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

26.1-18.1-14. Enrollment period and replacement coverage in the event of insolvency.

1. Enrollment period.

   a. In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

   b. If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for the groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

   c. The commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by the type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

2. Replacement coverage.

   a. "Discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health

maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

b. Any carrier providing replacement coverage with respect to group hospital, medical, or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior health maintenance organization contract or policy providing hospital, medical, or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

c. Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract may be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

45-06-13-04. Minimum net worth requirements. Prior to the issuance of a certificate of authority, a provider-sponsored organization must have a minimum net worth amount of:

1. At least one million five hundred thousand dollars except as provided in subsection 2.

2. No less than one million dollars based on evidence from the organization's financial plan demonstrating to the department's satisfaction that the organization has available to it an administrative infrastructure that the department considers appropriate to reduce, control, or eliminate startup administrative costs.

   a. After the effective date of a provider-sponsored organization's certificate of authority, a provider-sponsored organization shall maintain a minimum net worth amount equal to the greater of:

      (1) One million dollars;

      (2) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with the department for up to and including the first one hundred fifty million dollars of annual premiums and one percent of annual premium revenues on premiums in excess of one hundred fifty million dollars;

      (3) An amount equal to the sum of three months of uncovered health care expenditures as reported on the most recent financial statement filed with the department; or

(4) Using the most recent annual financial statement filed with the department, an amount equal to the sum of:

(a) Eight percent of annual health care expenditures paid on a noncapitated basis to nonaffiliated providers;

(b) Four percent of annual health care expenditures paid on a capitated basis to nonaffiliated providers plus annual health care expenditures paid on a noncapitated basis to affiliated providers; and

(c) Annual health care expenditures that are paid on a capitated basis to affiliated providers are not included in the calculation of the net worth requirement under subsection 1 and this paragraph.

b. The minimum net worth amount shall be calculated as follows:

(1) Cash requirement:

(a) At the time of the application for a certificate of authority, the provider-sponsored organization shall maintain at least seven hundred fifty thousand dollars of the minimum net worth amount in cash or cash equivalents.

(b) After the effective date of a provider-sponsored organization's certificate of authority, a provider-sponsored organization shall maintain the greater of seven hundred fifty thousand dollars or forty percent of the minimum net worth amount in cash or cash equivalents.

(2) Intangible assets. An organization may include intangible assets, the value of which is based on generally accepted accounting principles, in the minimum net worth amount calculation subject to the following limitations:

(a) At the time of application:

(i) Up to twenty percent of the minimum net worth amount, provided at least one million dollars of the minimum net worth amount is met through cash or cash equivalents; or

(ii) Up to ten percent of the minimum net worth amount, if less than one million dollars of the minimum net worth is met through cash or cash equivalents, or if the department has used its discretion under this subsection.

(b) From the effective date of the provider-sponsored organization's certificate of authority:

(i) Up to twenty percent of the minimum net worth amount if the greater of one million dollars or sixty-seven percent of the minimum net worth is met by cash or cash equivalents; or

(ii) Up to ten percent of the minimum net worth amount if the greater of one million dollars or sixty-seven percent of the minimum net worth amount is not met by cash or cash equivalents.

(3) Health care delivery assets. Subject to the other provisions of this section, a provider-sponsored organization may apply one hundred percent of the generally accepted accounting principles depreciated value of health care delivery assets to satisfy the minimum net worth amount.

(4) Other assets. A provider-sponsored organization may apply other assets not used in the delivery care provided that those assets are valued according to statutory accounting practices as defined by the department.

(5) Subordinated debts and subordinated liabilities. Fully subordinated debt and subordinated liabilities are excluded from the minimum net worth amount calculation.

(6) Deferred acquisition costs. Deferred acquisition costs are excluded from the calculation of the minimum net worth amount.

History
History: Effective August 1, 2000.
General authority
General Authority: NDCC 26.1-01-07.6
Law implemented
Law Implemented: NDCC 26.1-01-07.6

45-06-13-05. Financial plan requirements

1. General rule. At the time of application under section 45-06-13-03, an applicant must submit a financial plan acceptable to the department.

2. A financial plan must include:

   a. A detailed marketing plan;

   b. Statements of revenue and expense on an accrual basis;

   c. Statements of sources and uses of funds;

d. Balance sheets;

e. Detailed justifications and assumptions in support of the financial plan including, when appropriate, certification of reserves and actuarial liabilities by a qualified health maintenance organization actuary; and

f. If applicable, statements of the availability of financial resources to meet projected losses.

3. Period covered by the plan. A financial plan shall:

a. Cover the first twelve months after the estimated effective date of a provider-sponsored organization's medicare+choice contract; or

b. If the provider-sponsored organization is projecting losses, cover twelve months beyond the end of the period for which losses are projected.

4. Funding for projected losses. Except for the use of guarantees, letters of credit, and other means as provided in section 45-06-13-08, an organization shall have the resources for meeting projected losses on its balance sheet in cash or a form that is convertible to cash in a timely manner, in accordance with the provider-sponsored organization's financial plan.

5. Guarantees and projected losses. Guarantees will be an acceptable resource to fund projected losses, provided that a provider-sponsored organization:

a. Meets the department's requirements for guarantors and guarantee documents as specified in section 45-06-13-08; and

b. Obtains from the guarantor cash or cash equivalents to fund the projected losses timely, as follows:

(1) Prior to the effective date of a provider-sponsored organization's medicare+choice contract, the amount of the projected losses for the first two quarters;

(2) During the first quarter and prior to the beginning of the second quarter of a provider-sponsored organization's medicare+choice contract, the amount of projected losses through the end of the third quarter; and

(3) During the second quarter and prior to the beginning of the third quarter of a provider-sponsored organization's medicare+choice contract, the amount of projected losses through the end of the fourth quarter.

c. If the guarantor complies with the requirements in subdivision b, the provider-sponsored organization, in the third quarter, may notify the department of its intent to reduce the period of advance funding of projected losses. The department shall notify the provider-

sponsored organization within sixty days of receiving the provider-sponsored organization's request if the requested reduction in the period of advance funding will not be accepted.

d. If the guarantee requirements in subdivision b are not met, the department may take appropriate action, such as requiring funding of projected losses through means other than a guarantee. The department retains discretion to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

6. Letters of credit. Letters of credit are an acceptable resource to fund projected losses, provided they are irrevocable, unconditional, and satisfactory to the department. They shall be capable of being promptly paid upon presentation of a sight draft under the letters of credit without further reference to any other agreement, document, or entity.

7. Other means. If satisfactory to the department, and for periods beginning one year after the effective date of a provider-sponsored organization's medicare+choice contract, a provider-sponsored organization may use the following to fund projected losses:

   a. Lines of credit from regulated financial institutions;

   b. Legally binding agreements for capital contributions; or

   c. Legally binding agreements of a similar quality and reliability as permitted in subdivisions a and b.

8. Application of guarantees, letters of credit, or other means of funding projected losses. Notwithstanding any other provision of this section, a provider-sponsored organization may use guarantees, letters of credit, and, beginning one year after the effective date of a provider-sponsored organization's medicare+choice contract, other means of funding projected losses, but only in a combination or sequence that the department considers appropriate.

History
History: Effective August 1, 2000.
General authority
General Authority: NDCC 26.1-01-07.6
Law implemented
Law Implemented: NDCC 26.1-01-07.6

45-06-13-06. Liquidity

1. A provider-sponsored organization shall have sufficient cash flow to meet its financial obligations as they become due and payable.

2. To determine whether the provider-sponsored organization meets the requirement in subsection 1, the department will examine the following:

   a. The provider-sponsored organization's timeliness in meeting current obligations;

   b. The extent to which the provider-sponsored organization's current ratio of assets to liabilities is maintained at a one to one ratio including whether there is a declining trend in the current ratio over time; and

   c. The availability of outside financial resources to the provider-sponsored organization.

3. If the department determines that a provider-sponsored organization fails to meet the requirement in subdivision a of subsection 2, the department will require the provider-sponsored organization to initiate corrective action and pay all overdue obligations.
4. If the department determines that a provider-sponsored organization fails to meet the requirement of subdivision b of subsection 2, the department will require the provider-sponsored organization to initiate corrective action to:

   a. Change the distribution of its assets;

   b. Reduce its liabilities; or

   c. Make alternative arrangements to secure additional funding to restore the provider-sponsored organization's current ratio to one to one.

5. If the department determines that a provider-sponsored organization fails to meet the requirement of subdivision c of subsection 2, the department will require the provider-sponsored organization to obtain funding from alternative financial resources.

History
History: Effective August 1, 2000.
General authority
General Authority: NDCC 26.1-01-07.6
Law implemented
Law Implemented: NDCC 26.1-01-07.6

45-06-13-07. Deposits

1. Insolvency deposit.

   a. At the time of application, an organization shall deposit one hundred thousand dollars in cash or securities, or any combination thereof, into an account in a manner that is acceptable to the department.

b. The deposit must be restricted to use in the event of insolvency to help assure continuation of services or pay costs associated with receivership or liquidation.

c. At the time of the provider-sponsored organization's application for a certification of authority, and, thereafter, upon the department's request, a provider-sponsored organization shall provide the department with proof of the insolvency deposit, such proof to be in a form that the department considers appropriate.

2. Uncovered expenditures deposit.

a. If at any time uncovered expenditures exceed ten percent of a provider-sponsored organization's total health care expenditures, then the provider-sponsored organization must place an uncovered expenditures deposit into an account with any organization or trustee that is acceptable to the department.

b. The deposit must at all times have fair market value of an amount that is one hundred twenty percent of the provider-sponsored organization's outstanding liability for uncovered expenditures for enrollees, including incurred, but not reported, claims.

c. The deposit must be calculated as of the first day of each month required and maintained for the remainder of each month required.

d. If a provider-sponsored organization is not otherwise required to file a quarterly report, it must file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

e. The deposit required under this section is restricted and in trust for the department's use to protect the interests of the provider-sponsored organization's Medicare enrollees and to pay the costs associated with administering the insolvency. It may be used only as provided under this section.

3. Deposit as asset. A provider-sponsored organization may use the deposits required under subsections 1 and 2 to satisfy the provider-sponsored organization's minimum net worth amount required under section 45-06-13-04.

4. Income. All income from the deposits or trust accounts required under subsections 1 and 2 is considered assets of the provider-sponsored organization. Upon the department's approval, the income from the deposits may be withdrawn.

5. Withdrawal. On prior written approval from the department, a provider-sponsored organization that has made a deposit under subsection 1 or 2 may withdraw that deposit or any part thereof if:

a. A substitute deposit of cash or securities of equal amount and value is made;

b. The fair market value exceeds the amount of the required deposit; or

c. The required deposit under subsection 1 or 2 is reduced or eliminated.

History
History: Effective August 1, 2000.
General authority
General Authority: NDCC 26.1-01-07.6
Law implemented
Law Implemented: NDCC 26.1-01-07.6

45-06-13-08. Guarantees

1. General policy. A provider-sponsored organization, or the legal entity of which the provider-sponsored organization is a component, may apply to the department to use the financial resources of a guarantor for the purpose of meeting the requirements in section 45-06-13-05. The department has the discretion to approve or deny approval of the use of a guarantor.

2. Request to use a guarantor. To apply to use the financial resources of a guarantor, a provider-sponsored organization must submit to the department the following material:

   a. Documentation that the guarantor meets the requirements for a guarantor under subsection 3; and

   b. The guarantor's independently audited financial statements for the current year-to-date and for the two most recent fiscal years. The financial statements must include the guarantor's balance sheets, the profit and loss statements, and cash flow statements.

3. Requirements for guarantor. To serve as a guarantor, an organization must meet the following requirements:

   a. Be a legal entity authorized to conduct business within a state of the United States.

   b. Not be under federal or state bankruptcy or rehabilitation proceedings.

   c. Have a net worth, not including other guarantees, intangibles, and restricted reserves, equal to three times the amount of the provider-sponsored organization guarantee.

   d. If the guarantor is regulated by a state insurance commissioner, or other state official with authority for risk-bearing entities, it must meet the net worth requirement in subdivision c with all guarantees and all investments in and loans to organizations covered by guarantees excluded from its assets.

e. If the guarantor is not regulated by a state insurance commissioner or other similar state official, it must meet the net worth requirement in subdivision c with all guarantees and all investments in and loans to organizations covered by a guarantee and to related parties, subsidiaries, and affiliates excluded from its assets.

4. Guarantee document. If the guarantee request is approved, a provider-sponsored organization must submit to the department a written guarantee document signed by an appropriate authority of the guarantor. The guarantee document must contain the following provisions:

   a. State the financial obligation covered by the guarantee;

   b. Agree to unconditionally fulfill the financial obligation covered by the guarantee;

   c. Agree not to subordinate the guarantee to any other claim on the resources of the guarantor;

   d. Declare that the guarantor must act on a timely basis, in any case not more than five business days, to satisfy the financial obligation covered by the guarantee; and

   e. Meet other conditions as the department may establish from time to time.

5. Reporting requirement. A provider-sponsored organization shall submit to the department the current internal financial statements and annual financial statements of the guarantor according to the schedule, manner, and form that the department requests.

6. Modification, substitution, and termination of a guarantee. A provider-sponsored organization may not modify, substitute, or terminate a guarantee unless the provider-sponsored organization:

   a. Requests the department's approval at least ninety days before the proposed effective date of the modification, substitution, or termination;

   b. Demonstrates to the department's satisfaction that the modification, substitution, or termination will not result in insolvency of the provider-sponsored organization; and

   c. Demonstrates how the provider-sponsored organization will meet the requirements of this section.

7. Nullification. If at any time the guarantor or the guarantee ceases to meet the requirements of this section, the department shall notify the provider-sponsored organization that it ceases to recognize the guarantee document. In the event of this nullification, a provider-sponsored organization shall:

a. Meet the applicable requirements of this section within fifteen business days; and

b. If required by the department, meet a portion of the applicable requirements in less than the time period granted in subdivision a.

History
History: Effective August 1, 2000.
General authority
General Authority: NDCC 26.1-01-07.6
Law implemented
Law Implemented: NDCC 26.1-01-07.6

26.1-12-08. License required - Prerequisites to issuance of license. A mutual insurance company organized under this chapter may not issue policies or transact any insurance business unless it holds a license from the commissioner authorizing the transaction of insurance business. The license may not be issued unless and until the company complies with the following conditions:

1. It must hold bona fide applications for insurance upon which it will issue simultaneously at least twenty policies to at least twenty members for the same kind of insurance upon not less than two hundred separate risks, each within the maximum single risk.

2. It must have collected a premium upon each application. All premiums must be held in cash or in securities in which insurance companies may invest, and in the case of fire insurance, must be equal to not less than twice the maximum single risk assumed subject to one fire nor less than ten thousand dollars, and in any other kind of insurance as listed in section 26.1-12-11, to not less than five times the maximum single risk assumed nor less than ten thousand dollars.

3. It must maintain a surplus of at least one million dollars. However, for any company doing business only in this state, if the minimum assets and surplus requirements required by this subsection are more than the minimum requirements at the time the company was issued its original certificate of authority to do business, the company may maintain assets and surplus which satisfy the requirements in effect at that time. For all other companies, if the minimum assets and surplus requirements required by this subsection are more than the minimum requirements required at the time the company was issued its original certificate of authority, the company shall increase its surplus of assets over all liabilities according to the following schedule:

   a. Two hundred fifty thousand dollars by December 31, 1994.

   b. Five hundred thousand dollars by December 31, 1995.

   c. Seven hundred fifty thousand dollars by December 31, 1996.

d. One million dollars by December 31, 1997.

CHAPTER 26.1-03.2 RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS

26.1-03.2-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

5. "Health organization" means a health maintenance organization, prepaid limited health service organization, nonprofit health service corporation, or other managed care organization licensed by the commissioner to do business in this state. "Health organization" does not include an organization that is licensed as either a life and health insurer or a property and casualty insurer that is otherwise subject to either the life or property and casualty risk-based capital requirements.

6. "Risk-based capital instructions" means the risk-based capital report including risk-based capital instructions adopted by the national association of insurance commissioners, as these risk-based capital instructions may be amended by the national association of insurance commissioners from time to time in accordance with the procedures adopted by the national association of insurance commissioners.

7. "Risk-based capital level" means a health organization's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital and:

   a. "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

   b. "Company action level risk-based capital" means, with respect to any health organization, the product of 2.0 and its authorized control level risk-based capital.

   c. "Mandatory control level risk-based capital" means the product of .70 and the authorized control level risk-based capital.

   d. "Regulatory action level risk-based capital" means the product of 1.5 and its authorized control level risk-based capital.

26.1-03.2-02. Risk-based capital reports.

1. On or before each March first, a domestic health organization shall prepare and submit to the commissioner a report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing such information as is required by the risk-based capital instructions. In addition, a domestic health organization shall file its risk-based capital report:

   a. With the national association of insurance commissioners in accordance with the risk-based capital instructions; and

b. With the insurance commissioner in any state in which the health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its risk-based capital report not later than the latter of:

(1) Fifteen days from the receipt of notice to file its risk-based capital report with that state; or

(2) The filing date.

2. A health organization's risk-based capital must be determined in accordance with the formula set forth in the risk-based capital instructions. The formula must take the following into account, and may adjust for the covariance between, as determined in each case by applying the factors in the manner set forth in the risk-based capital instructions:

a. Asset risk;

b. Credit risk;

c. Underwriting risk; and

d. All other business risks and such other relevant risks as are set forth in the risk-based capital instructions.

3. Net worth over the amount produced by the risk-based capital requirements contained in this chapter and the formulas, schedules, and instructions referenced in this chapter is desirable in the business of health insurance. Accordingly, health organizations should seek to maintain capital above the risk-based capital levels required by this chapter. Additional capital is used and useful in the insurance business and helps to secure a health organization against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this chapter.

Enrollment process in the absence of an automatic default enrollment process.

The vast majority of enrollees select their MCE on a timely basis in the county social service agency. Of the total statewide eligible for Medicaid managed care, less than 1% do not select an MCE immediately. This number drops to .5% after 60 days from the date the enrollee is informed they need to select an MCE. If an enrollee has difficulty selecting an MCE, the criteria listed in Supplement 2 are used to assist the enrollees.

If an MCE is not selected, the following process is used:

1. A monthly notice is generated and mailed to the enrollee who has not selected an MCE. The automated eligibility system completes this task. This notice continues to be generated as long as the enrollee does not select an MCE.

2. The same system that generates the enrollee notice also provides an alert to the enrollee's county eligibility worker to inform the worker their client has not selected an MCE and that the notice has been sent.

3. To facilitate the process, staff from the NDDHS receives a monthly report presenting the enrollees throughout the state that have not selected an MCE. The report contains the enrollee name, medical assistance identification number, medical assistance case number, and the date the enrollee was informed to select an MCE. The report is sorted by:
   a. Date from the MCE informed date; 1 to 60 days, 61 to 90 days, 91 to 180 days, and over 180 days.
   b. By county social service agency
   c. By county case worker

   Copies of the report are sent to county social services supervisors to ensure their workers address the issue. The state staff reviews and compares the monthly reports to identify enrollees that continue to not select an MCE.

Qualified External Quality Review Organization

Currently, the only qualified External Quality Review Organization in North Dakota is a peer review organization, North Dakota Health Care Review, Inc. NDDHS currently contracts with North Dakota Health Care Review to provide the following services:

1. Preauthorization of Services with an annual review by provider of these services
   - Cosmetic
   - Obesity
2. Review claims for medical appropriateness
3. Track referrals and outcomes
4. Chart review
5. Compile and report on identified diagnosis/disease through claims and encounter data
6. Provider Profiling
   - Readmission rates by provider
   - Discharge summaries
   - Provider review by peer group
   - Focused review on identified DRGs
7. Provide education seminars for Medical Assistance staff
8. Assist in questions from, and used as reference by, the Medical Assistance staff

The external quality review will include, but is not limited to the following issues:

1. Validation of MCO encounter data
2. Assessment of MCO information system capability
3. Review of MCO administration of enrollee survey
4. Validation of enrollee survey results
5. Validation of performance measures
6. Validation of performance improvement projects

Survey Statistics

In a state-wide sample survey conducted in 2000 of the Medical Assistance enrollees, the aid category pertaining to the Medicaid managed care program:

Survey question: During the past 12 months (or since you have been eligible for Medicaid if less than 12 months), when you have made appointments with a doctor nurse, about how long did it take to get in?

Amount of time taken to get in to see doctor/nurse

- Within 1 day = 30%
- Within 1 week = 47%
- Within 2 weeks = 16%
- More than 2 weeks = 7%

Opinion of the length of time between "want" and "get" appointment

- Excellent = 30%
- Very good = 28%
- Good = 24%
- Fair = 14%
- Poor = 4%

Emergency room visits made past 12 months

- Never = 51%
- Once = 24%
- Twice = 13%
- 3 times = 8%
- 4 to 5 times = 3%
- 6 or more times = 1%

Distance one-way from enrollee's home to doctor/nurse/clinic most often seen

- Mean distance = 10.4 miles
- Median distance = 3 miles
- Maximum = 135 miles

Times unable to get needed medical care

- No = 80%
- Yes = 20%

Opinion of convenience of doctor/nurse location

- Excellent = 41%
- Very good = 25%
- Good = 24%
- Fair = 8%
- Poor = 2%

Opinion of the doctor's, nurse's hours of operation

- Excellent = 29%
- Very good = 30%
- Good = 26%
- Fair = 12%
- Poor = 3%

Opinion of time spent in waiting room

- Excellent = 15%
- Very good = 25%
- Good = 27%
- Fair = 24%
- Poor = 9%

Opinion of the ease in reaching doctor by phone during regular office hours

- Excellent = 20%
- Very good = 25%
- Good = 26%
- Fair = 19%
- Poor = 10%

Opinion of the ease in reaching doctor by phone after regular office hours

- Excellent = 10%
- Very good = 17%
- Good = 24%
- Fair = 26%
- Poor = 23%

Opinion of the availability to the same doctor at each visit

- Excellent = 28%
- Very good = 33%
- Good = 23%
- Fair = 12%
- Poor = 4%

Opinion of the ease of getting a referral to another doctor

- Excellent = 24%
- Very good = 30%
- Good = 24%
- Fair = 12%
- Poor = 10%